PRINTED: 07/29/2020 FORM APPROVED

Division of Health Care Facilities

NAME OF PROVIDER OR SUPPLIER NEWPORT HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 135 GENERATION DRIVE NEWPORT, TN 37821 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 135 GENERATION DRIVE NEWPORT, TN 37821 (X4) ID PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments Investigation of complaints #51189, #51213, #51455, #51501, #51503 and a COVID-19 Focused Survey was conducted on 7/13/2020-7/16/2020 at Newport Health And Rehabilitation Center. No health deficiencies were cited under Chapter 1200-8-6, Standards for						I		
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#51455, #51501, #51503 and a COVID-19 Focused Survey was conducted on 7/13/2020-7/16/2020 at Newport Health And Rehabilitation Center. No health deficiencies were cited under Chapter 1200-8-6, Standards for	N 000	Initial Comments		N 000				
	N 0000	Investigation of comp #51455, #51501, #51 Focused Survey was 7/13/2020-7/16/2020 Rehabilitation Center cited under Chapter	503 and a COVID-19 conducted on at Newport Health And . No health deficiencies were	N 000				

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE